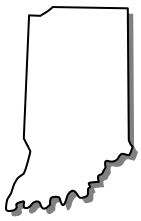

INDIANA HEALTH COVERAGE PROGRAMS

Chapter 6: Prior Authorization Edits 3000-3999

Revision History

Document Version Number	Revision Date	ReviSion Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 1999	All	Updated edits and audits	Leanna Collisi and Brandy Ludlum
Version 1.2	June 2000	6-1-10	Update edits and audits	Leanna Collisi and Charlene Schweikhart
Version 2.1	March 2001	6-1-9	Update edit 3005	Charlene Schweikhart
Version 2.3	September 2001	6-1-5	Update edit 3002	Charlene Schweikhart
Version 3.3	September 2002	6-1-24	New edit 3017	Susan Mariutto
Version 3.4	December 2002	6-1-4	Update edit 3001	Susan Mariutto
Version 4.3	September 2003	6-1-10	Update edit 3005	Susan Mariutto
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Version 6.1	March 31, 2005	Various	Update edits 3000, 3001, 3002, 3003, 3004, 3005, 3006, 3007, 3008, 3009, 3010. 3011, 3012, and 3014.	Leo Dabbs
Version 6.3	October 5, 2005	Various	Update edits 3002, 3004, 3005, 3009, 3017, and 3018.	Leo Dabbs
Version 6.4	December 31, 2006	6-1-6	Update edit 3001.	Leo Dabbs
Version 7.2	June 30, 2006	6-1-6	Update edit 3001.	Leo Dabbs

Table of Contents

Section 1: Prior Authorization Edits 3000-3999

Overview

Prior authorization edits are performed to ascertain that billed services that require prior authorization have been prior authorized. These edits check the services on the claim and verify that the procedure, the quantity, and the amount billed match the procedure, the quantity, and the amount authorized.

If a prior authorization is successfully matched with the claim and the claim is adjudicated for payment, the authorized units or the amount on the prior authorization will be decremented by the units or the amount paid on the claim. This is a two-step process. The first procedure will verify the presence of an approved prior authorization that matches the claim. If a match is made, the claim is allowed to go through the entire processing cycle until it is approved for payment. Prior to payment, the prior authorization is again accessed to decrement the units or the amount to be paid on the claim. Claims that are submitted for more than the units or the amount authorized will be cut back to match the number of units or the amount authorized on the prior authorization table.

As other claim types and programs are defined, exceptions to these edits can be identified and the edits can then be changed or modified to prevent valid claims from being suspended or denied.

Edit: ESC 3000 Units Exceed PA Master

Note: Edit 3000 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, M, P, Q	03	All	Detail	No	Yes	0

Disposition	Full Failure	Cutback
Paper Claim	Deny	Pay
ECS	Deny	Pay
Shadow	Pay	Pay
POS	Deny	Pay
Adjustments	**Deny**	Pay
Special Batch	Deny	Pay

Edit Description

Fail this edit if the number of units billed by the provider for a prior authorized service or procedure code exceeds the unused number of units prior authorized for the date of service.

Edit Criteria

If the number of units billed by the provider for a prior authorized service or procedure code needing a PA exceeds the unused number of units prior authorized as noted on the PA database for the date of service, fail this edit with EOB 3000, cutback, and pay the claim up to the number of units that have been prior authorized.

The system will review the PA file for the presence of a PA for any HCPC procedure within the range of 10000-99999. However, the PA unit(s) on file will only be decreased by the provider that bills one of the above procedure codes with no modifier, or one of the following modifiers (26, 50, 51, 54, 55, 56, 78). Any other claim, outpatient or physician, billed by other specialties, for example, assistant surgeon or assistant anesthesiologist, will only verify with the system that PA has been approved for the procedure billed, and not actually deduct from the unit(s) available on the PA file. The reason for this is that more than one provider may be involved with the same recipient on the same date of service for the same procedure, but only one PA is needed per procedure, not per specialty billing. This logic allows other specialties to have claims paid when claims have the same recipient, same dates of service, and same procedure the provider that bills no modifier or one of the following modifiers (26, 50, 51, 54, 55, 56, 78), even though a PA has not been assigned.

This edit will bypass 590 claims with a detailed billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D), or an admit type of 1 for inpatient (I)

claims will bypass this edit. An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

All claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3000 – Payment has been cut back to the number of units authorized on PA.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

N45 – Payment based on authorized amount.

Method of Correction

- Full Failure
  - Claims failing this edit systematically deny.
- Cutback
  - Claims failing this edit systematically cutback.

Edit: ESC 3000 Units Exceed PA Master

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, M, P, Q	03	All	Detail	No	Yes	0

Disposition	Full Failure	Cutback
Paper Claim	Deny	Pay
ECS	Deny	Pay
Shadow	Pay	Pay
POS	Deny	Pay
Adjustments	Suspend	Pay
Special Batch	Deny	Pay

Edit Description

Fail this edit if the number of units billed by the provider for a prior authorized service or procedure code exceeds the unused number of units prior authorized for the date of service.

Edit Criteria

If the number of units billed by the provider for a prior authorized service or procedure code needing a PA exceeds the unused number of units prior authorized as noted on the PA database for the date of service, fail this edit with EOB 3000, cutback, and pay the claim up to the number of units that have been prior authorized.

The system will review the PA file for the presence of a PA for any HCPC procedure within the range of 10000-99999. However, the PA unit(s) on file will only be decreased by the provider that bills one of the above procedure codes with no modifier, or one of the following modifiers (26, 50, 51, 54, 55, 56, 78). Any other claim, outpatient or physician, billed by other specialties, for example, assistant surgeon or assistant anesthesiologist, will only verify with the system that PA has been approved for the procedure billed, and not actually deduct from the unit(s) available on the PA file. The reason for this is that more than one provider may be involved with the same recipient on the same date of service for the same procedure, but only one PA is needed per procedure, not per specialty billing. This logic allows other specialties to have claims paid when claims have the same recipient, same dates of service, and same procedure the provider that bills no modifier or one of the following modifiers (26, 50, 51, 54, 55, 56, 78), even though a PA has not been assigned.

This edit will bypass 590 claims with a detailed billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D), or an admit type of 1 for inpatient (I) claims will bypass this edit. An emergency indicated by any of the diagnosis codes

listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

All claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3000 – Payment has been cut back to the number of units authorized on PA.

Method of Correction

- Full Failure
  - Claims failing this edit systematically deny.
- Cutback
  - Claims failing this edit systematically cutback.

Edit: ESC 3001 Date(s) of Service Not On PA Database

Note: Edit 3001 revised April 24, 2006.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O, P, Q	03	All, except PASRR	Detail	Yes	Yes	0

Disposition	D, M, O, P, Q	H	MRT
Paper Claim	Deny	Deny	**Suspend**
ECS	Deny	Deny	**Suspend**
Shadow	Pay	Pay	Pay
POS	Deny	Deny	Pay
Adjustments	Deny	Deny	**Suspend**
Special Batch	Deny	Deny	**Suspend**

Edit Description

Fail this edit if the system verifies that the code billed requires prior authorization (PA) for the program (for example, Medicaid, PCM, RBMC, and so forth) in which the member is enrolled, and the service dates indicated on the claim for the code that needs prior authorization, do not fall within the start or stop dates prior authorized for that code.

Edit Criteria

The system initially determines whether the code billed requires PA for the program (for example, Medicaid, PCCM, RBMC, and so forth) in which the member is enrolled. If the code billed requires PA for that program, and the service dates indicated on the claim do not fall within the start or stop dates prior authorized for that code, fail this edit with EOB 3001.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), **Medical (M)**, and dental claims (D). An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed. Additionally, pregnancy or newborn diagnosis codes will bypass PA. Pregnancy is indicated by diagnosis group 33 and newborn by diagnosis group 3 for the outpatient, home health, or medical claims.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3001 – Dates of service not on PA master file.

3019 – Dates of service for service billed not on P.A. master file. Please refer to Bulletin BT 200514, for appropriate billing of MRT services. Prior Authorization

may be obtained from the MRT unit by contacting (317) 232-2028 (Medical) or (317) 233-5725 (Psychiatric).

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit systematically deny.

MRT claims will suspend to the Resolution Team Lead, and direction will come from the State as to how to proceed with the claim.

Edit: ESC 3001 Date(s) of Service Not On PA Database

Note: Edit 3001 revised November 16, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O, P, Q	03	**All, except PASRR**	Detail	Yes	Yes	0

Disposition	D, M, O, P, Q	H	MRT
Paper Claim	Deny	Deny	**Deny**
ECS	Deny	Deny	**Deny**
Shadow	Pay	Pay	**Pay**
POS	Deny	Deny	**Pay**
Adjustments	Deny	Deny	**Deny**
Special Batch	Deny	Deny	**Deny**

Edit Description

Fail this edit if the system verifies that the code billed requires prior authorization (PA) for the program (for example, Medicaid, PCM, RBMC, and so forth) in which the member is enrolled, and the service dates indicated on the claim for the code that needs prior authorization, do not fall within the start or stop dates prior authorized for that code.

Edit Criteria

The system initially determines whether the code billed requires PA for the program (for example, Medicaid, PCCM, RBMC, and so forth) in which the member is enrolled. If the code billed requires PA for that program, and the service dates indicated on the claim do not fall within the start or stop dates prior authorized for that code, fail this edit with EOB 3001.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D). An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3001 – Dates of service not on PA master file.

3019 – Dates of service for service billed not on P.A. master file. Please refer to Bulletin BT 200514, for appropriate billing of MRT services. Prior Authorization may be obtained from the MRT unit by contacting (317) 232-2028 (Medical) or (317) 233-5725 (Psychiatric).

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claim types D, H, M, O, P, Q.

Claims failing this edit systematically deny.

Edit: ESC 3001 Date(s) of Service Not On PA Database

Note: Edit 3001 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O, P, Q	03	All	Detail	Yes	Yes	0

Disposition	D, M, O, P, Q	H
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	Deny	Deny
Adjustments	**Deny**	**Deny**
Special Batch	**Deny**	**Deny**

Edit Description

Fail this edit if the system verifies that the code billed requires prior authorization (PA) for the program (for example, Medicaid, PCM, RBMC, and so forth) in which the member is enrolled, and the service dates indicated on the claim for the code that needs prior authorization, do not fall within the start or stop dates prior authorized for that code.

Edit Criteria

The system initially determines whether the code billed requires PA for the program (for example, Medicaid, PCCM, RBMC, and so forth) in which the member is enrolled. If the code billed requires PA for that program, and the service dates indicated on the claim do not fall within the start or stop dates prior authorized for that code, fail this edit with EOB 3001.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D). An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3001 – Dates of service not on PA master file.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claim types D, H, M, O, P, Q
- Claims failing this edit systematically deny.

Edit: ESC 3001 Date(s) of Service Not On PA Database

Note: Edit 3001 revised November 21, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O, P, Q	03	All	Detail	Yes	Yes	0

Disposition	D, M, O, P, Q	H
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	Deny	**Deny**
Adjustments	N/A	**N/A**
Special Batch	Pay	**Suspend**

Edit Description

Fail this edit if the system verifies that the code billed requires prior authorization (PA) for the program (for example, Medicaid, PCM, RBMC, and so forth) in which the member is enrolled, and the service dates indicated on the claim for the code that needs prior authorization, do not fall within the start or stop dates prior authorized for that code.

Edit Criteria

The system initially determines whether the code billed requires PA for the program (for example, Medicaid, PCCM, RBMC, and so forth) in which the member is enrolled. If the code billed requires PA for that program, and the service dates indicated on the claim do not fall within the start or stop dates prior authorized for that code, fail this edit with EOB 3001.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D). An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3001 – Dates of service not on PA master file.

Method of Correction

- Claim types D, H, M, O, P, Q
  - Claims failing this edit systematically deny

Edit: ESC 3001 Date(s) of Service Not On PA Database

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O, P, Q	03	All	Detail	Yes	Yes	0

Disposition	D, M, O, P, Q	H
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	Deny	N/A
Adjustments	N/A	Deny
Special Batch	Pay	Deny

Edit Description

Fail this edit if the system verifies that the code billed requires PA for the program (for example, Medicaid, PCM, RBMC, and so forth) in which the recipient is enrolled, and the service dates indicated on the claim for the code that needs prior authorization, do not fall within the start/stop dates prior authorized for that code.

Edit Criteria

The system initially determines whether the code billed requires PA for the program (for example, Medicaid, PCCM, RBMC, and so forth) in which the recipient is enrolled. If the code billed requires PA for that program, and the service dates indicated on the claim do not fall within the start/stop dates prior authorized for that code, fail this edit with EOB 3001.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of Y on pharmacy (P), compound drug (Q), and dental claims (D). An emergency indicated by any of the diagnosis codes listed in diagnosis group 21, located in *Appendix A*, for outpatient, home health, or medical claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3001 – Dates of service not on PA master file.

Method of Correction

- Claim types D, H, M, O, P, Q
  - Claims failing this edit systematically deny.

Edit: ESC 3002 NDC Requires Prior Authorization Not Found

Note: Edit 3002 revised October 5, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	03	All	Detail	No	Yes	0

Disposition	P	Q
00 Other	**Deny**	**Deny**
20 ECS w/o attach	**Deny**	**Deny**
22 Shadow	**Pay**	**Pay**
50 Voids/Replacement non-check related	**Deny**	**Deny**
51 Voids/Replacement check related	**Deny**	**Deny**
52 Shadow Replacement	**Deny**	**Deny**
53 Shadow Claims Void	**Deny**	**Pay**
55 Mass Replacement NH	**Deny**	**Pay**
56 Mass Replacement FIN	**Deny**	**Deny**

Edit Description

Fail this edit if a claim is submitted for a NDC that requires PA and no PA is on file for the NDC billed.

Edit Criteria

If a claim is submitted and the PA indicator on the NDC file indicates the need for a PA and an approved PA is not found, fail this edit with EOB 3002.

Bypass this edit for 590 claims with a billed amount less than or equal to $500 or with an emergency indicator of **Y**. An emergency is acceptable if on diagnosis group table 21 (see *Appendix A*).

Claims billed with a provider specialty of 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3002 – NDC requires prior authorization, no approved PA on file.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

None.

NCPDP Reject Code

75 – Prior Authorization Required.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3002 NDC Requires Prior Authorization Not Found

Note: Edit 3002 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	03	All	Detail	No	Yes	0

Disposition	P	Q
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	**Pay**	Pay
POS	Deny	Deny
Adjustments	Deny	Suspend
Special Batch	Deny	Deny

Edit Description

Fail this edit if a claim is submitted for a NDC that requires PA and no PA is on file for the NDC billed.

Edit Criteria

If a claim is submitted and the PA indicator on the NDC file indicates the need for a PA and an approved PA is not found, fail this edit with EOB 3002.

Bypass this edit for 590 claims with a billed amount less than or equal to $500 or with an emergency indicator of **Y**. An emergency is acceptable if on diagnosis group table 21 (see *Appendix A*).

Claims billed with a provider specialty of 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3002 – NDC requires prior authorization, no approved PA on file.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3002 NDC Requires Prior Authorization Not Found

Note: Edit 3002 revised August 27, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	03	All	Detail	No	Yes	0

Disposition	P	Q
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	**Pay**	Pay
POS	Deny	Deny
Adjustments	Deny	Suspend
Special Batch	Deny	Deny

Edit Description

Fail this edit if a claim is submitted for a NDC that requires PA and no PA is on file for the NDC billed.

Edit Criteria

If a claim is submitted and the PA indicator on the NDC file indicates the need for a PA and an approved PA is not found, fail this edit with EOB 3002.

Bypass this edit for 590 claims with a billed amount less than or equal to $500 or with an emergency indicator of **Y**. An emergency is acceptable if on diagnosis group table 21 (see *Appendix A*).

Claims billed with a provider specialty of 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3002 – NDC requires prior authorization, no approved PA on file.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3002 NDC Requires Prior Authorization Not Found

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	03	All	Detail	No	Yes	0

Disposition	P	Q
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Deny	Pay
POS	Deny	Deny
Adjustments	Deny	Suspend
Special Batch	Deny	Deny

Edit Description

Fail this edit if a claim is submitted for a NDC that requires PA and no PA is on file for the NDC billed.

Edit Criteria

If a claim is submitted and the PA indicator on the NDC file indicates the need for a PA and an approved PA is not found, fail this edit with EOB 3002.

Bypass this edit for 590 claims with a billed amount less than or equal to $500 or with an emergency indicator of **Y**. An emergency is acceptable if on diagnosis group table 21 (see *Appendix A*).

Claims billed with a provider specialty of 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3002 – NDC requires prior authorization, no approved PA on file.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3003 Procedure Code Requires PA

Note: Edit 3003 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, O	03	All	Detail	No	Yes	0

Note: Although AIM *appears to show this edit is active, this edit's criteria has been removed from the Jackson, thus, no claims will hit this edit. Edit 3001 replaces this edit.*

Disposition	D, H, O
Paper Claim	**Deny**
ECS	**Deny**
Shadow	**Pay**
POS	**Deny**
Adjustments	**Deny**
Special Batch	**Deny**

Edit Description

Fail this edit if the claim's procedure code requires, but has not received prior authorization.

Edit Criteria

If the procedure code on the claim does not have prior approval on the prior authorization database, fail this edit with EOB 3003.

Home Health Claims (H):

For home health claims, PA is NOT required for home health services within 30 days of the hospital discharge date as indicated by a value of 50 and the hospital discharge date in the occurrence code/date fields. However, the services are **not to exceed 120 hours**.

Outpatient Claims (O) and Home Health Claims (H):

This edit will bypass for outpatient and home health claims if an emergency indicator of **Y** is present. An emergency is acceptable for diagnosis group table 21 (see *Appendix A*).

EOB Code

3003 – Procedure code requires PA, no approved PA on file.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit will systematically deny.

Edit: ESC 3003 Procedure Code Requires PA

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, O	03	All	Detail	No	Yes	0

Note: Although AIM *appears to show this edit is active, this edit's criteria has been removed from the Jackson, thus, no claims will hit this edit. Edit 3001 replaces this edit.*

Disposition	D, H, O
Paper Claim	N/A
ECS	N/A
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	N/A

Edit Description

Fail this edit if the claim's procedure code requires, but has not received prior authorization.

Edit Criteria

If the procedure code on the claim does not have prior approval on the prior authorization database, fail this edit with EOB 3003.

Home Health Claims (H):

For home health claims, PA is NOT required for home health services within 30 days of the hospital discharge date as indicated by a value of 50 and the hospital discharge date in the occurrence code/date fields. However, the services are **not to exceed 120 hours**.

Outpatient Claims (O) and Home Health Claims (H):

This edit will bypass for outpatient and home health claims if an emergency indicator of **Y** is present. An emergency is acceptable for diagnosis group table 21 (see *Appendix A*).

EOB Code

3003 – Procedure code requires PA, no approved PA on file.

Method of Correction

N/A

Edit: ESC 3004 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3004 revised September 9, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O	00	All **except Package C, MRT, and PASRR**	Detail	Yes	Yes	0

Disposition	D, H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Interactive
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if dates of service on claim spans multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the date of service on a claim span multiple spenddown multiple spenddown periods and the spenddown is not met in each month for the date of service on the claim, fail this edit with EOB 3004.

EOB Code

3004 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

8/25/05: Updated ARC to 178 – Payment adjusted because the patient has not met the required spend-down requirements.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3004 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3004 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O	00	All except Package C	Detail	Yes	Yes	0

Disposition	D, H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	**Interactive**
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if dates of service on claim spans multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the date of service on a claim span multiple spenddown multiple spenddown periods and the spenddown is not met in each month for the date of service on the claim, fail this edit with EOB 3004.

EOB Code

3004 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3004 Claim Spans Multiple Spenddown Periods and Not Met

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O	00	All except Package C	Detail	Yes	Yes	0

Disposition	D, H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if dates of service on claim spans multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the date of service on a claim span multiple spenddown multiple spenddown periods and the spenddown is not met in each month for the date of service on the claim, fail this edit with EOB 3004.

EOB Code

3004 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3005 revised September 9, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All	Header	Yes	Yes	0

Disposition	A, B, C	I, L	P, Q
Paper Claim	Deny	Deny	Deny
ECS	Deny	Deny	Deny
Shadow	**Inactive**	**Inactive**	**Inactive**
POS	Deny	Deny	Deny
Adjustments	Deny	Deny	Deny
Special Batch	Suspend	Suspend	Deny

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 3005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Method of Correction

For crossover claims and inpatient claims, check member's spenddown for months billed and verify that member has not met spenddown for the first month billed. If recipient has met spenddown for the first month billed, force the claim to pay. Otherwise, deny the claim. All other claim types failing this edit systematically deny.

Note: These claims should be sent to Written Correspondence for special batching.

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3005 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All	Header	Yes	Yes	0

Disposition	A, B, C	I, L	P, Q
Paper Claim	Deny	Deny	Deny
ECS	Deny	Deny	Deny
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Deny
Adjustments	**Deny**	**Deny**	Deny
Special Batch	Suspend	Suspend	Deny

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 3005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Method of Correction

For crossover claims and inpatient claims, check member's spenddown for months billed and verify that member has not met spenddown for the first month billed. If recipient has met spenddown for the first month billed, force the claim to pay. Otherwise, deny the claim. All other claim types failing this edit systematically deny.

Note: These claims should be sent to Written Correspondence for special batching.

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3005 revised July 14, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All	Header	Yes	Yes	0

Disposition	A, B, C	I, L	P, Q
Paper Claim	Deny	Deny	**Deny**
ECS	Deny	Deny	**Deny**
Shadow	Deny	Deny	**Deny**
POS	Deny	Deny	**Deny**
Adjustments	Suspend	Suspend	**Deny**
Special Batch	Suspend	Suspend	**Deny**

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 3005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

Method of Correction

For crossover claims **and inpatient claims,** check member's spenddown for months billed and verify that member has not met spenddown for the first month billed. If recipient has met spenddown for the first month billed, force the claim to pay. Otherwise, deny the claim.

All other claim types failing this edit systematically deny.

Note: These claims should be sent to Written Correspondence for special batching

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3005 revised March 27, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All	Header	Yes	Yes	0

Disposition	A, B, C	I, L, P, Q
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Deny	Deny
POS	Deny	Deny
Adjustments	Suspend	Suspend
Special Batch	Suspend	**Suspend**

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 3005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

Method of Correction

For crossover claims, check member's spenddown for months billed and verify that member has not met spenddown for the first month billed. If recipient has met spenddown for the first month billed, force the claim to pay. Otherwise, deny the claim.

All other claim types failing this edit systematically deny.

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit 3005 revised June 7, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All	Header	Yes	Yes	0

Disposition	A, B, C	I, L, P, Q
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Deny	Deny
POS	Deny	Deny
Adjustments	Suspend	Suspend
Special Batch	Suspend	Deny

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 3005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

Method of Correction

For crossover claims, check member's spenddown for months billed and verify that member has not met spenddown for the first month billed. If recipient has met spenddown for the first month billed, force the claim to pay. Otherwise, deny the claim.

All other claim types failing this edit systematically deny.

Edit: ESC 3005 Claim Spans Multiple Spenddown Periods and Not Met

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I, L, P, Q	00	All except Package C	Header	Yes	Yes	0

Disposition	A, B, C, I, L, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Suspend
Special Batch	Deny

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim.

Edit Criteria

If the dates of service on the claim span multiple spenddown periods and the spenddown is not met in each month for the dates of service on the claim, fail this edit with EOB 2005.

EOB Code

3005 – This claim covers multiple months and spenddown has not been met for all months billed on the claim.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3006 PA Dollars Exhausted

Note: Edit 3006 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O, P, Q	03	All	Detail	No	Yes	0

Disposition	Full Failure	Cutback
Paper Claim	Deny	Pay
ECS	Deny	Pay
Shadow	Pay	Pay
POS	Deny	Pay
Adjustments	**Deny**	Pay
Special Batch	Deny	Pay

Edit Description

Fail this edit if the approved dollar amount on the PA file has already been exhausted.

Edit Criteria

If a claim requiring an approved PA is submitted and there is an approved PA on file but the approved dollars have already been used on previous claims, fail this edit with EOB 3006.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of **Y** on pharmacy (P), compound drug (Q), and dental claims (D), or an admit type of **1** for long term (L) claims will bypass this edit. An emergency indicated by any of the diagnosis codes listed in diagnosis group 21 (see *Appendix A*) for outpatient (O), home health (H), or medical (M) claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3006 – Claim denied. Approved dollar amount on PA exhausted by previous claim(s).

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

- Full failure
  - Claims failing this edit systematically deny.
- Cutback
  - Claims failing this edit systematically cutback.

Edit: ESC 3006 PA Dollars Exhausted

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O, P, Q	03	All	Detail	No	Yes	0

Disposition	Full Failure	Cutback
Paper Claim	Deny	Pay
ECS	Deny	Pay
Shadow	Pay	Pay
POS	Deny	Pay
Adjustments	Suspend	Pay
Special Batch	Deny	Pay

Edit Description

Fail this edit if the approved dollar amount on the PA file has already been exhausted.

Edit Criteria

If a claim requiring an approved PA is submitted and there is an approved PA on file but the approved dollars have already been used on previous claims, fail this edit with EOB 3006.

This edit will bypass 590 claims with a detail billed amount less than or equal to $500. For all other benefit programs, an emergency indicator of **Y** on pharmacy (P), compound drug (Q), and dental claims (D), or an admit type of **1** for long term (L) claims will bypass this edit. An emergency indicated by any of the diagnosis codes listed in diagnosis group 21 (see *Appendix A*) for outpatient (O), home health (H), or medical (M) claims would also cause this edit to be bypassed.

Claims billed with a provider specialty of 120 (school corporation) or 212 (CSHCS health care coordinator) will bypass this edit.

EOB Code

3006 – Claim denied. Approved dollar amount on PA exhausted by previous claim(s).

Method of Correction

- Full failure
  - Claims failing this edit systematically deny.
- Cutback
  - Claims failing this edit systematically cutback.

Edit: ESC 3007 No Prior Authorization Segment for Level of Care

Note: Edit 3007 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if no prior authorization is on file for psych., burn, or rehab. levels of care.

Edit Criteria

If no prior authorization segment is on file for psych., burn, or rehab. levels of care, fail this edit with EOB 3007.

Inpatient claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3007 – No PA segment on file for the level of care.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3007 No Prior Authorization Segment for Level of Care

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if no prior authorization is on file for psych., burn, or rehab. levels of care.

Edit Criteria

If no prior authorization segment is on file for psych., burn, or rehab. levels of care, fail this edit with EOB 3007.

Inpatient claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3007 – No PA segment on file for the level of care.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3008 Prior Authorized Units Equal Zero

Note: Edit 3008 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	**Deny**
Special Batch	**Deny**

Edit Description

Fail this edit if there are no units prior authorized on file for level of care.

Edit Criteria

If no units are present on the prior authorization file for level of care, fail this edit with EOB 3008.

Inpatient claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3008 – There are no units prior authorized on file for level of care.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3008 Prior Authorized Units Equal Zero

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit if there are no units prior authorized on file for level of care.

Edit Criteria

If no units are present on the prior authorization file for level of care, fail this edit with EOB 3008.

Inpatient claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3008 – There are no units prior authorized on file for level of care.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3009 QMB-Also Claims Spans Multiple Periods

Note: Edit 3009 revised September 9, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O	00	All **except MRT and PASRR**	Detail	Yes	Yes	0

Disposition	H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Inactive
POS	N/A
Adjustments	Deny
Special Batch	N/A

Edit Description

Fail this edit if the claim's recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed.

Edit Criteria

If the recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed, fail this edit with EOB 3009.

EOB Code

3009 – This service is not payable, recipient is QMB-Also and spenddown has not been met for all months billed. Only reimbursement for Medicare coinsurance and deductible is available. Bill Medicare first.

ARC Code

109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

8/25/05: Updated ARC to 178 – Payment adjusted because the patient has not met the required spend-down requirements.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3009 QMB-Also Claims Spans Multiple Periods

Note: Edit 3009 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O	00	All	Detail	Yes	Yes	0

Disposition	H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	**Inactive**
POS	N/A
Adjustments	**Deny**
Special Batch	N/A

Edit Description

Fail this edit if the claim's recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed.

Edit Criteria

If the recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed, fail this edit with EOB 3009.

EOB Code

3009 – This service is not payable, recipient is QMB-Also and spenddown has not been met for all months billed. Only reimbursement for Medicare coinsurance and deductible is available. Bill Medicare first.

ARC Code

109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3009 QMB-Also Claims Spans Multiple Periods

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O	00	All	Detail	Yes	Yes	0

Disposition	H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	N/A
Adjustments	Suspend
Special Batch	N/A

Edit Description

Fail this edit if the claim's recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed.

Edit Criteria

If the recipient is QMB-Also and the dates of service span multiple spenddown periods and the spenddown has not been met in each month for the dates of service billed, fail this edit with EOB 3009.

EOB Code

3009 – This service is not payable, recipient is QMB-Also and spenddown has not been met for all months billed. Only reimbursement for Medicare coinsurance and deductible is available. Bill Medicare first.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3010 Out-of-State Provider Requires Prior Authorization

Note: Edit 3010 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, O, P, Q	03	All Except Disability	Header	Yes	Yes	0

Disposition	D, H, I, L, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	**Deny**
Special Batch	Deny

Edit Description

Fail this edit if a claim is submitted by an out-of-state billing provider for non-emergency services and there is no prior authorization on file for the service. See below for what constitutes an emergency.

Edit Criteria

When a claim is submitted by an out-of-state provider (locality equals out-of-state), for any non-emergency services and there is no prior authorization on file, fail this edit with EOB 3010.

For inpatient claims the system will only look for prior authorization if the revenue code billed is listed on revenue group 17 (see *Appendix A*).

Providers in the following cities with county code=OOS-Ward Crt., will bypass this edit:

Cincinnati, Ohio	Danville, Ill.	Hamilton, Ohio
Harrison, Ohio	Louisville, Ky.	Owensboro, Ky.
Oxford, Ohio	Sturgis, Mich.	Watseka, Ill.

All claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

Table 6-1.1 - Emergencies

Indicator	Description
Pharmacy (P)/compound drug (Q)	Value of **Y** in the EMG field.
Outpatient (O)/home health (H)	Diagnosis submitted which is part of the emergency diagnosis group 21 (see *Appendix A*).
Dental (D)	Value of **Y** in the emergency field. Data entry operators will key in an **E** in the place of treatment field and REI will create and transmit an emergency indicator.
Inpatient (I)	Value of **1** in the admit type on the header of the UB-92.

EOB Code

3010 – Non-emergency out-of-state services require prior authorization.

ARC Code

62 – Payment denied, reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

M58 – Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3010 Out-of-State Provider Requires Prior Authorization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, O, P, Q	03	All Except Disability	Header	Yes	Yes	0

Disposition	D, H, I, L, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Suspend
Special Batch	Deny

Edit Description

Fail this edit if a claim is submitted by an out-of-state billing provider for non-emergency services and there is no prior authorization on file for the service. See below for what constitutes an emergency.

Edit Criteria

When a claim is submitted by an out-of-state provider (locality equals out-of-state), for any nonemergency services and there is no prior authorization on file, fail this edit with EOB 3010.

For inpatient claims the system will only look for prior authorization if the revenue code billed is listed on revenue group 17 (see *Appendix A*).

Providers in the following cities with county code=OOS-Ward Crt., will bypass this edit:

Cincinnati, Ohio	Danville, Ill.	Hamilton, Ohio
Harrison, Ohio	Louisville, Ky.	Owensboro, Ky.
Oxford, Ohio	Sturgis, Mich.	Watseka, Ill.

All claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

Table 6-1.2 - Emergencies

Indicator	Description
Pharmacy (P)/compound drug (Q)	Value of **Y** in the EMG field.

(Continued)

Table 6-1.2 - Emergencies

Indicator	Description
Outpatient (O)/home health (H)	Diagnosis submitted which is part of the emergency diagnosis group 21 (see *Appendix A*).
Dental (D)	Value of **Y** in the emergency field. Data entry operators will key in an **E** in the place of treatment field and REI will create and transmit an emergency indicator.
Inpatient (I)	Value of **1** in the admit type on the header of the UB-92.

EOB Code

3010 – Nonemergency out-of-state services require prior authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3011 Out-of-State Provider Requires Prior Authorization – Rendering Provider

Note: Edit 3011 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, I, M, O, Q	03	All Except Disability Determination	Detail	Yes	Yes	0

Disposition	D, I, O, Q	M
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	N/A	N/A
Adjustments	Deny	**Deny**
Special Batch	Deny	Deny

Edit Description

Fail this edit if a claim is submitted with an out-of-state rendering provider for non-emergency services and there is no prior authorization on file for the service.

Edit Criteria

When a claim is submitted with an out-of-state rendering provider (locality equals out-of-state), for any non-emergency services (as indicated by the emergency indicator of a N on the detail of the claim) and there is no prior authorization on file, fail this edit with EOB 3011.

Claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

Providers in the following cities with county code=00S-Ward Crt, will bypass this edit:

Cincinnati, Ohio	Danville, Ill.	Hamilton, Ohio
Harrison, Ohio	Louisville, Ky.	Owensboro, Ky.
Oxford, Ohio	Sturgis, Mich.	Watseka, Ill.

EOB Code

3011 – Non-emergency out-of-state services require prior authorization.

ARC Code

62 – Payment denied, reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

M58 – Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3011 Out-of-State Provider Requires Prior Authorization – Rendering Provider

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, I, M, O, Q	03	All Except Disability Determination	Detail	Yes	Yes	0

Disposition	D, I, O, Q	M
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	N/A	N/A
Adjustments	Deny	Suspend
Special Batch	Deny	Deny

Edit Description

Fail this edit if a claim is submitted with an out-of-state rendering provider for nonemergency services and there is no prior authorization on file for the service.

Edit Criteria

When a claim is submitted with an out-of-state rendering provider (locality equals out-of-state), for any non-emergency services (as indicated by the emergency indicator of a N on the detail of the claim) and there is no prior authorization on file, fail this edit with EOB 3011.

Claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

Providers in the following cities with county code=00S-Ward Crt, will bypass this edit:

Cincinnati, Ohio	Danville, Ill.	Hamilton, Ohio
Harrison, Ohio	Louisville, Ky.	Owensboro, Ky.
Oxford, Ohio	Sturgis, Mich.	Watseka, Ill.

EOB Code

3011 – Non-emergency out-of-state services require prior authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3012 Transportation Exceeding Fifty Miles Requires Prior Authorization

Note: Edit 3012 revised February 11, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	03	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	**Deny**
Special Batch	Deny

Edit Description

Fail this edit if no prior authorization is found on the PA file for more than 50 miles.

Edit Criteria

If an excess of 50 miles is billed with a procedure group 12 (transportation requires PA) and no PA is found on file, fail this edit with EOB 3012.

Claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

This edit will bypass 590 claims with a detail-billed amount less than or equal to $500 or an emergency indicator of Y.

EOB Code

3012 – Transportation services exceeding 50 miles require PA.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3012 Transportation Exceeding Fifty Miles Requires Prior Authorization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	03	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Deny

Edit Description

Fail this edit if no prior authorization is found on the PA file for more than 50 miles.

Edit Criteria

If an excess of 50 miles is billed with a procedure group 12 (transportation requires PA) and no PA is found on file, fail this edit with EOB 3012.

Claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

This edit will bypass 590 claims with a detail-billed amount less than or equal to $500 or an emergency indicator of Y.

EOB Code

3012 – Transportation services exceeding 50 miles require PA.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3013 Prior Authorization for Anesthesia

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	03	All	Detail	Yes	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Deny

Note: This edit is not coded in the system to be active, thus no claims will fail for this edit.

Edit Description

Fail this edit if a claim is submitted for a service that requires prior authorization and the specialty is 140, 311, or 101 and there is no prior authorization on the line item PA table.

Also fail this edit if the specialty is 270-276 and 310, 312-345 with Modifier 47 (physician billing for anesthesia).

Edit Criteria

When a claim is submitted with a procedure code that requires prior authorization, and the specialty is 140, 311, or 101 or if the specialty is 270-276 and 310, 312-345 with modifier 47 (physician billing for anesthesia), and there is no prior authorization on the line item PA table, fail this edit with EOB 3013.

This edit should only check for the presence of PA and NOT decrement the PA file.

Claims with provider specialty 212 (CSHCS care coordinator) will bypass this edit.

EOB Code

3013 – Dates of service not on PA master file.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3014 Substance Abuse DRG Requires Prior Authorization

Note: Edit 3014 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	No	No	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when an inpatient claim is submitted for a substance abuse service and an approved PA record is not on file. This edit applies to DRG range 748-751.

Edit Criteria

PA is required for inpatient detoxification, rehabilitation, and care for chemical dependency, thus, when an inpatient claim is submitted for a substance abuse service that maps to a DRG between 748 and 751, and an approved PA record is not on file, fail this edit with EOB 3001.

EOB Code

3001 – Dates of service not on the PA master file.

ARC Code

62 – Payment denied, reduced for absence of, or exceeded, pre-certification/authorization.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3014 Substance Abuse DRG Requires Prior Authorization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	03	All	Header	No	No	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when an inpatient claim is submitted for a substance abuse service and an approved PA record is not on file. This edit applies to DRG range 748-751.

Edit Criteria

PA is required for inpatient detoxification, rehabilitation, and care for chemical dependency, thus, when an inpatient claim is submitted for a substance abuse service that maps to a DRG between 748 and 751, and an approved PA record is not on file, fail this edit with EOB 3001.

EOB Code

3001 – Dates of service not on the PA master file.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3015 Out-of-State Noncovered Services

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
L	21	All	Header	No	Yes	0

Disposition	L
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a claim is submitted for an out-of-state nursing facility, or any other type of extended care service. This edit will fail if the billing provider's locality or county code equals out-of-state, OOS-Ward, or IFSSA on the provider service location window.

Edit Criteria

According to *405 IAC 5-5-2 (b)(1 & 2)*, the following services will not be covered outside of Indiana and are not covered outside of Indiana for designated cities listed in *405 IAC 5-5-2 (a)(3 through 4)*:

- Nursing facilities or ICFs/MR,
- Any other type of LTC facility, including facilities directly associated with or part of an acute general hospital.

When a claim is submitted for an out-of-state nursing facility, residential facility, or any other type of LTC facility with bill type 210, 211, 215, 650, 651, 655, 660, 661, 665, 670, 671, or 675, fail this edit with EOB 3015. Prior authorization will **not** override this edit.

The system code for this edit only considers the long-term care claim type (L).

EOB Code

3015 – LTC services provided outside of Indiana are noncovered services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3016 Out-of-State Home Health Services Are Noncovered

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	03	All	Detail	No	No	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a claim is submitted for an out-of-state home health service. This edit will fail if the billing provider's locality or county code equals out-of-state, OOS-Ward, or IFSSA on the provider service location window.

Edit Criteria

According to *405 IAC 5-5-1*, Indiana Health Insurance Coverage Programs reimbursement is available for the following services:

Acute general hospital care	Physician services	Dental services
Pharmacy services	Transportation services	Therapy services
Podiatry services	Chiropractic services	
Durable medical equipment and supplies		

When a claim is submitted for an out-of-state home health agency with bill type 330, 331, and 335, fail this edit with EOB 3016. An approved prior authorization **will** override this edit.

EOB Code

3016 – Home health services provided outside of Indiana are noncovered services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 3017 NDC Not on Preferred Drug List

Note: Edit 3017 revised October 5, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	03	All except 590	Detail	No	No	0

Disposition	P, Q
00 Other	**Deny**
22 Shadow	**Pay**
52 Shadow Replacement	**Pay**
53 Shadow Claim Void	**Pay**

Edit Description

Fail this edit when a billed NDC is not on the Preferred Drug List as approved by the OMPP.

Edit Criteria

Fail this edit with EOB 3017, if the NDC hits a pharmacy program that begins with PDL, does not have any exclusions or exceptions, and the appropriate PDL program prior authorization is not on file.

EOB Code

3017 – This NDC is not on the IHCP Preferred Drug List. Prior authorization is required. Please have the prescriber contact ACS at 1-866-879-0106 for prior authorization.

ARC Code

62 – Payment denied/ reduced for absence of, or exceed.

Remark Code

None.

NCPDP Reject Code

75 – Prior Authorization Required.

Method of Correction

Claims failing this edit systematically deny. Only PA can override them.

Edit: ESC 3017 NDC Not on Preferred Drug List

Note: Edit 3017 NEW effective August 14, 2002

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	**03**	**All except 590**	**Detail**	**No**	**No**	**0**

Disposition	H
Paper Claim	**Deny**
ECS	**Deny**
Shadow	**Pay**
POS	**Deny**
Adjustments	**Deny**

Edit Description

Fail this edit when a billed NDC is not on the Preferred Drug List as approved by the OMPP.

Edit Criteria

Fail this edit with EOB 3017, if the NDC hits a pharmacy program that begins with PDL, does not have any exclusions or exceptions, and the appropriate PDL program prior authorization is not on file.

EOB Code

3017 – This NDC is not on the IHCP Preferred Drug List. Prior authorization is required. Please have the prescriber contact ACS at 1-866-879-0106 for prior authorization.

Method of Correction

Claims failing this edit systematically deny. Only PA can override them.

Edit: ESC 3018 Claim Spans Multiple Spenddown Periods and Not Met

Note: Edit revised September 9, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
B	00	All	Header	Yes	Yes	0

Disposition	B
Paper Claim	Suspend
ECS	CCF
Shadow	Pay
POS	Pay
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim and the procedure code on the claim resides on Procedure Group 180 Diabetic Supplies, and the claim is type B and the recipient is dual aid eligible.

Procedure Group 180 Diabetic Supplies

A4244 Alcohol or peroxide, per pint
A4245 Alcohol wipes, per box
A4246 Betadine or iodine swabs/wipes, per pint
A4247 Betadine or iodine swabs/wipes, per box
A4250 Urine test or reagent strips or tablets (100 tablets or strips)
A4253 Blood glucose test or reagent strips, per 50 strips
A4254 Replacement battery, any type, for use with medically necessary home blood…..
A4255 Platforms for home blood glucose monitor, 50 per box
A4256 Normal, low and high calibrator, solution/chips
A4257 Replacement lens shield cartridge for use with laser skin piercing device, each
A4258 Spring-powered device for lancet, each
A4259 Lancets, per box of 100

Edit Criteria

If the dates of service on the claim span multiple spenddown periods and the spenddown is not met in each month for the dates of service on the claim, and the procedure code on the claim resides on Procedure Group 180 Diabetic Supplies, and the claim is type B and the recipient is dual aid eligible, fail this edit with EOB 3018.

EOB Code

3018 – Claim spans multiple months and spenddown has not been met, (Diabetic Supplies).

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

8/25/05: Updated ARC to 178 – Payment adjusted because the patient has not met the required spend-down requirements.

Method of Correction

- All electronic crossover claims type B, failing this edit will be systematically returned to provider for 8A form (CCF).
- All paper claims failing this edit will suspend to review for 8A form.
- Reso will check the 8A for the first month of the span:
  - If 8A is present for the first month of the span and the date of service is the same as the date spenddown was met, force edit and apply deductible if one is present
  - If 8A is present for the first month of the span and spenddown was met after the date of service on the claim, deny the edit

If no 8A is returned for the first month of the span, deny the edit.

Edit: ESC 3018 Claim Spans Multiple Spenddown Periods and Not Met

Note: New Audit effective December 1, 2004.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
B	**00**	**All**	**Header**	**Yes**	**Yes**	**0**

Disposition	B
Paper Claim	**Suspend**
ECS	**CCF**
Shadow	**Pay**
POS	**Pay**
Adjustments	**Suspend**
Special Batch	**Suspend**

Edit Description

Fail this edit when dates of service on claim span multiple spenddown periods, and the spenddown is not met in each month for the dates of service on the claim and the procedure code on the claim resides on Procedure Group 180 Diabetic Supplies, and the claim is type B and the recipient is dual aid eligible.

Procedure Group 180 Diabetic Supplies

A4244 Alcohol or peroxide, per pint
A4245 Alcohol wipes, per box
A4246 Betadine or iodine swabs/wipes, per pint
A4247 Betadine or iodine swabs/wipes, per box
A4250 Urine test or reagent strips or tablets (100 tablets or strips)
A4253 Blood glucose test or reagent strips, per 50 strips
A4254 Replacement battery, any type, for use with medically necessary home blood…..
A4255 Platforms for home blood glucose monitor, 50 per box
A4256 Normal, low and high calibrator, solution/chips
A4257 Replacement lens shield cartridge for use with laser skin piercing device, each
A4258 Spring-powered device for lancet, each
A4259 Lancets, per box of 100

Edit Criteria

If the dates of service on the claim span multiple spenddown periods and the spenddown is not met in each month for the dates of service on the claim, and the procedure code on the claim resides on Procedure Group 180 Diabetic Supplies, and the claim is type B and the recipient is dual aid eligible, fail this edit with EOB 3018.

EOB Code

3018 – Claim spans multiple months and spenddown has not been met, (Diabetic Supplies).

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Method of Correction

- **All electronic crossover claims type B, failing this edit will be systematically returned to provider for 8A form (CCF).**
- **All paper claims failing this edit will suspend to review for 8A form.**
- **Reso will check the 8A for the first month of the span:**
  - **If 8A is present for the first month of the span and the date of service is the same as the date spenddown was met, force edit and apply deductible if one is present**
  - **If 8A is present for the first month of the span and spenddown was met after the date of service on the claim, deny the edit**

If no 8A is returned for the first month of the span, deny the edit.

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